MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

676682 2

Reg. Dist. No. 626

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne-Arundel

City or town: Odenton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Nell ~~Franis~~ Frances Alman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Vernie F Alman

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): November 24 1923

8. AGE: Years	Months	Days	If less than one day
24	9	21	— hrs. — min.

9. Birthplace: Bristol Tenn (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER

12. Name: Edward Franklin Helmadollar

13. Birthplace: Tazewell [redacted] Virginia

MOTHER

14. Maiden name: Eliza Jane Davis

15. Birthplace: Tazewell [redacted] Virginia

16. Informant: Eliza Helmadollar

Address: Odenton

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19 1947 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: Ridgly Selby

Address: 401 Wash Ave Laurel Md

19. Sept 18 1947 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1947 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1947, to September 16 1947 and that I last saw her alive on September 16 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward G Merritt M.D. (M.D. or other)

Address: Gambrills Md Date signed: 9-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

07669

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 144 Duke of Gloucester St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME William T. Barber

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma S. Barber

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10th 1874

8. AGE: Years	Months	Days	If less than one day
72	11	24	hrs. min.

9. Birthplace: Annapolis A.A.Co. Md.
(Town, county, and state)

10. Usual occupation: Ret. Conductor of B.&A. RR.

11. Industry or business

FATHER 12. Name: William H. Barber

13. Birthplace: Annapolis, Md.

MOTHER 14. Maiden name: Susan R. Wells

15. Birthplace: A. A. Co. Maryland

16. Informant: Mrs. Emma S. Barber

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Tayloe + Son

Address: Annapolis, Md.

19. Sept. 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4 1947 at 3 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28 1947 to Sept 3 1947 and that I last saw h.. alive on Sept 3 1947

Immediate cause of death	DURATION
Diabetes mellitus	15 yrs
Due to: General Arterio-sclerosis	15 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D.
M. D. or other

Address: Annapolis Md Date signed: Sept. 6. 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07670

93d

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs

Hospital, Institution, or street address where death occurred:
30 Madison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 Madison St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JAMES H. BEALL

3.(b) Social Security Number: 214-05-1022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virgie B[illegible]. Beall

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): July 24, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	12	___ hrs. ___ min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Doorman

11. Industry or business

FATHER
12. Name: John L. Beall
13. Birthplace: New York

MOTHER
14. Maiden name: Mary[illegible] A. Lamb
15. Birthplace: Annapolis, Maryland

16. Informant: Mrs. Virgie B. Beall

Address: 30 Madison St. Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1947 (month) (day) (year)

Cemetery or crematory: Edwards Chapel Cemetery

Location: Parole, A.A. Co. Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Sept. 8 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6, 1947 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1947 to Sept 6, 1947 and that I last saw him alive on Sept 6, 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Since 9/1/47
Due to	
Due to	
Other conditions Arteriosclerotic-Cardio-Vascular Disease	7 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

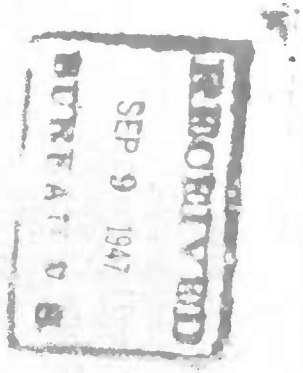
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson MD. M.D. or other

Address: Annapolis, Md. Date signed 9/6/47.



VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07671

181

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft George G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Months - 7 days.
Hospital, institution, or street address where death occurred:
Barracks Hospital
How long in hospital or institution? - - - DOA

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Fayette
City or town: New Salem
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 704
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: George J. Bohatch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Helen F. Bohatch
6.(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): 12 Oct 1917

8. AGE: Years	Months	Days	If less than one day
29	11	5	- hrs. - min.

9. Birthplace: Carpentertown, Pa. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unavailable
13. Birthplace: Austria, Hungary

MOTHER
14. Maiden name: Helen NMI (Unavailable)
15. Birthplace: Austria, Hungary

16. Informant: Service records of deceased.
Address: Ft Geo G Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 18 Sep 1947 (month) (day) (year)
Cemetery or crematory: Masontown, Pa.
Location: Masontown, Pa.

18. Funeral director: Lilly & Zeiler, Inc.
Address: 403 S. Wolfe St., Baltimore, Md.

19. 17 Sep 1947 (Date rec'd by registrar) Joseph Goerger JAMES N. GOERGER, CAPT. MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 September 1947, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on DEAD ON ARRIVAL 19.....

Immediate cause of death	DURATION
(a) PULMONARY EDEMA	-
Due to: SMOKE INHALATION	
Due to:	
Other conditions: ACUTE BRONCHITIS EXTENSIVE 3RD DEGREE BURNS	

(Include pregnancy within 3 months of death)

Major findings of operation: NONE Date of op.
Autopsy results: PULMONARY EDEMA.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9/17/47
Where did injury occur? - (City or town) Ft. Meade (County) Md. (State)
Injured at home, farm, industry, public place (where?) -
Means of injury: Fire Injured at work?

23. SIGNATURE: Allen G Ilmo Jr M.D. or other
Address: Station Hosp. Ft G Meade Md Date signed: 18 Sept 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07672

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 464 Tubmans Court
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EUREL BRINKLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Sadie Brinkley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us Nov. 8-1895

8. AGE: Years	Months	Days	If less than one day
51	?	?	hrs. min.

9. Birthplace: ? N.C. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: Unknown to us

FATHER
12. Name: Edward Brinkley
13. Birthplace: ? N.C

MOTHER
14. Maiden name: ? Rushel Savage
15. Birthplace: N.C.

16. Informant: Hospital Records

Address: Crownsville State Hospital, Maryland

17. (Burial, cremation, or removal. Which?) B Date thereof 9-6-47 (month) (day) (year)

Cemetery or crematory: Western Star WESTERN STAR

Location: Balto. Co.

18. Funeral director: Samuel W. Sullivan Jr.

Address: 1011 N. Arlington Ave Balto.

19. 9/4 19 47 C.W. Holland Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3rd 1947 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6th 1947 to September 3rd 1947 and that I last saw him alive on September 3rd 1947

Immediate cause of death: General Paresis	DURATION
	Known to us since 8/6/47
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 9-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07673

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Severna Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months.
Hospital, Institution, or street address where death occurred: Res.
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Maryland. County: Anne Arundel.
City or town: Severna Park. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cypress Creek Road. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Underhill Brown.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White.	Married.

6.(b) Name of husband or wife: Rev. Henry S. Brown.
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): May 2, 1882.

8. AGE:

Years	Months	Days	If less than one day
65	4	9	...hrs. ...min.

9. Birthplace: Elmira N.Y.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: at home.

FATHER
12. Name: Harry Underhill
13. Birthplace: Elmira. N.Y.

MOTHER
14. Maiden name: Harriet Bridley.
15. Birthplace: Elmira. N.Y.

16. Informant: Rev Henry S. Brown.
Address: Severna Park. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Sept. 13, 1947. (month) (day) (year)
Cemetery or crematory: Lasaine Park Cem
Location: Baltimore Md.
18. Funeral director: John M. Laylor & Son
Address: Annapolis. Md.

19. Sept. 13 1947 L. A. Breit
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11, 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May. 1947 to Sept 11. 1947 and that I last saw h alive on Sept 11 1947

Immediate cause of death	DURATION
General Carcinoma —	6 month.
Due to: Carcinoma of the Throat.	3 years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James S. Bullington M.D.
M. D. or other
Address: Glen Burnie. Date signed: Sept 12 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07731

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Green Haven - Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 Yrs.
Hospital, Institution, or street address where death occurred:
Outing Ave. and 7th. St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Green Haven - Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Outing Ave. and 7th. st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: IDA M. BROWNLEY (Mrs. [illegible])

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: R. Wesley Brownley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 1, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	26	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home
FATHER 12. Name: George Bowers
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Katheran Zapp
15. Birthplace: Baltimore, Md.
16. Informant: Mrs. Henry Ruppertsberger, Sr.
Address: Glen Burnie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 1, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Carmel Cemetery
Location: Baltimore, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. 9-27 (Date rec'd by registrar) 19 47 L. A. Breit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27, 1947, at 9:53P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-14-47 to 9-27-47
and that I last saw her alive on 9-23-47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	
Due to	
(NOTE: above information certified by Mrs. L.A. Breit, wife of physician, confirmed by the doctor's records at home. Physician is hospitalized and unable to complete this certificate at this time.) Letter	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
from Mrs. Breit filmed G113 10-23-47 L
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. A. Breit M. D.
M. D. or other
Address: Pasadena Md Date signed: 9-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02674 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 10 months, 15 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 2 years, 10 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1208 Madison Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CARRIE CARROLL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 36 | Months: ? | Days: ? | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Georeg Carroll
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Moore
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Oct. 2. 1947
(month) (day) (year)

Cemetery or crematory: Asbury Cem.

Location: Asbury Md.

18. Funeral director: Mrs Robert Elliott + daughter

Address: 1129 N. Caroline St

19. 9/30/47 19 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28th 19 47 at 2:20P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13, 1944 19 to September 28 19 47 and that I last saw her alive on September 28th 19 47

Immediate cause of death	DURATION
Tuberculosis of the Lungs	Known to us since 5/16/47
Due to:	
Due to:	
Other conditions: Schizophrenia, Simple Type (Include pregnancy within 3 months of death)	Known to us since 11/13/44

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Thompson M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 9/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

07675

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs.

Hospital, Institution, or street address where death occurred: Middle Ground - mar Bld. 854

How long in hospital or institution? DOA-Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: A. A.

City or town: Severna

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Meriview Road.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James N. Chesgreen

3. (b) Social Security Number: 212-14-5852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Azula Penny

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/2/94

8. AGE: Years	Months	Days	If less than one day
53	1	12	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business

FATHER — 12. Name: Charles F. Chesgreen

FATHER — 13. Birthplace: Whitewell, Maryland.

MOTHER — 14. Maiden name: Mary E. Kines

MOTHER — 15. Birthplace: Maryland.

16. Informant: Fort George G. Meade Records

Address: Fort George G. Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5 Sept. 1947 (month) (day) (year)

Cemetery or crematory: Savage, Maryland

Location: Savage, Maryland

18. Funeral director: Donaldson Funeral Home

Address: Laurel, Maryland

19. 5 Sept. 1947 (Date rec'd by registrar) James N. Goerger

JAMES N. GOERGER, Capt., Registrar

MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4 19 47, at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Fauber M.D.

M. D. or other

Address: Glen Burnie Md. Date signed: 9/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07676 28

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 23 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital Maryland

How long in hospital or institution? 2 months 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 N. Carey St Balto
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Charles Henry Comegys

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Melba Comegys

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1891

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace: Chestertown, Md.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business

FATHER 12. Name: Robert Comegys

13. Birthplace: Chestertown, Md.

MOTHER 14. Maiden name: ?

15. Birthplace

18. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arbutus Sept 16, 47.

Location: Balto Md.

18. Funeral director: Eater L. Williams

Address: 3224 E Chase St

19. Sept 15 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 19 47, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 19 47, to September 12 19 47 and that I last saw him alive on September 12 19 47

Immediate cause of death: General Paresis — DURATION: Known to us since June 20 47

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Brazenton M.D. M. D. or other

Address: Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

07677 C

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 10 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Maryland

How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1021 W. Lanvale Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Dowdy CHARLES DAUGHERTY (Daughtie)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mary Daugherty

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11/15/1898

8. AGE: Years	Months	Days	If less than one day
48	9	23	..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborere

11. Industry or business

FATHER 12. Name: William Daugherty

FATHER 13. Birthplace: North Carolina

MOTHER 14. Maiden name: Mandy

MOTHER 15. Birthplace: North Carolina

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 13, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Crematory

Location: Baltimore Maryland

16. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder Street

19. 9/10 (Date rec'd by registrar) 1947 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7th 1947 at 12:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28th 1947 to September 7th 1947 and that I last saw him alive on September 7th 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	Two weeks
due to hypertension	
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	Known to us since July 28th-47

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of .....

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ---------- Injured at work?

23. SIGNATURE: Jack Augenstein M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 9/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07678 28

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 554 Wilson Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Martha DAVIS (Pinn)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro	Married

6.(b) Name of husband or wife: was known to us

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1915

8. AGE: Years	Months	Days	If less than one day
32	7	29	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Charles Pinn

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Sarah Williams

15. Birthplace: ✓

16. Informant: Hospital records

Address: Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 17, 1947 (month) (day) (year)

Cemetery or crematory: Arbutus Mem. Park

Location: Baltimore Co. Md.

18. Funeral director: Mrs. George H. Holland

Address: 1681 Druid Hill Ave.

19. 9/16/47 (Date rec'd by registrar) 19 A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1947, at 7 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1947, to September 13 1947

and that I last saw h alive on September 13 1947

Immediate cause of death	DURATION
General paresis	d
known to us since	May 3, 47
Due to	
Due to	
Other conditions: Pulmonary tuberculosis known to us since	d May 3, 47

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: Jacob Augustus M.D. M. D. or other

Address: Crownsville State Hosp. Date signed: 9-14-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07679

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 5 months, 4 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 year, 5 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 10 South Carlton Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CLARENCE DENNIS

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Cora Dennis
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1887
8. AGE: Years: 60 Months: ? Days: ? If less than one day: hrs. min.
9. Birthplace: ~~Unknown~~ Balto Md (Town, county, and state)
10. Usual occupation: ~~Unknown~~ Laborer
11. Industry or business:
FATHER 12. Name: ~~Unknown~~ Edward Dennis
13. Birthplace: Md
MOTHER 14. Maiden name: ~~Unknown~~ Florence Harris
15. Birthplace: Md
16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 26 47 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemt
Location: A. A. Co. Md
18. Funeral director: Isaac L Brown Son
Address: 1060 Montgomery St
19. Sept 24 19 47 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23rd 1947 at 5:50A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1946 to September 23 47 and that I last saw him alive on September 23rd 1947

Immediate cause of death	DURATION
General Paresis	Known to us since April 19, 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Nungester M. D.
M. D. or other
Address: Crownsville, Maryland Date signed: 9/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07680

1700

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Maurice Dore (alias Peter Done)

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Sadie Done
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): Oct 2 1887
8. AGE: Years: 59 Months: 11 Days: 15 If less than one day: hrs. min.
9. Birthplace: Bristol, Md.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: County B.A.
FATHER 12. Name: John Done
13. Birthplace: Maryland
MOTHER 14. Maiden name: Annie Robinson
15. Birthplace: Maryland
16. Informant: Mrs Sadie Done
Address: Harwood Co, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20-47 (month) (day) (year)
Cemetery or crematory: All Hallows
Location: Brightwille, Maryland
18. Funeral director: Ben L. Hopkins & Son
Address: Annapolis, Maryland
19. Sept. 19 1947 (Date rec'd by registrar) W. O. Munch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 1947 at 9:35 P. M.
21. I CERTIFY that death occurred on the date above stated, ~~and to the cause and manner~~
Postmortem Examination
~~as stated below.~~ Sept 17 1947

	DURATION
Immediate cause of death: Crushed right Chest	sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 9/17/47
Where did injury occur? New Mt. Zion, (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Hazzard's Sand Pit
Means of injury: Caught between shovel and truck Injured at work? yes
23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/17/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07681

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Reference

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or Institution? Since 9/1/47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Murray Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish - American War

3.(a) FULL NAME: Alexander Evans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 7 1874

8. AGE: Years 73 | Months 7 | Days 27 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis - A.A.Co. - Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Odd

FATHER
12. Name: Alexander Evans
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: unknown Sarah K. Wheeler
15. Birthplace: unknown A.A.Co. Md.

16. Informant: Matthew Evans
Address: Severna Park - A.A.Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Sept. 4 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 1947 at 4:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to Sept. 3, 1947 and that I last saw him alive on September 3, 1947

Immediate cause of death	DURATION
Arteriosclerotic - Cardio - Vascular disease	1y.
Due to:	
Due to:	
Other conditions: Chronic Interstitial nephritis (Include pregnancy within 3 months of death)	1y.
	20dys

Major findings of operations: Medical Case

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other

Address: Annapolis, Md. Date signed 9/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Maryland State
[redacted] HEALTH DEPARTMENT 93d

CERTIFICATE OF DEATH

Registered No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore~~ City, Maryland — Anne Arundel
(b) Street address — Green Haven Md
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 07682
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5007 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Anna Frankel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business,

FATHER
12. Name Nicen
13. Birthplace Russia

MOTHER
14. Maiden Name Shania
15. Birthplace Russia

16 (a) Informant Max Frankel
(b) Address 5007 Denmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) 9/16/47 (Date rec'd by registrar) (b) A. W. Jedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15- 1947, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 15 1947. and that I last saw her alive on Sept 15 1947.

Immediate cause of death Chronic myocarditis, Coronary Occlusion — Duration one hour

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** Thos. A. H. Phillips M.D.
Address 8307 Edmondson Ave Date signed 9-16-47

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157 W

Reg. Dist. No. 076838

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Crownsvill, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20yrs. 5mo. 4days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 20yrs. 5mo. 4days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Handy - Clara

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882 ?

8. AGE: Years	Months	Days	If less than one day
45	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Will Handy

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Fannie Lewis

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 9/22-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt - Hospital

Address: Crownsville Md

19. 9/22-47 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 1947 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to Sept. 19 19 47

and that I last saw her alive on Sept. 19 47

Immediate cause of death: Chronic myocarditis — DURATION: about 2yrs

Due to: congenital Hydrocephalus — congential

Due to:

Other conditions: Mental deficiency with phychosis known to us since Oct. 1941 (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jack Marguerite M. D. M. D. or other

Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

07684 / 23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 23

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: a.a.
(a) ~~Baltimore City,~~ Maryland Brooklyn
(b) Street address 5513 Magie St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 5513 Magie St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Addie Harman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex fem
5. Color or race wh
6 (a) Single, married, widowed, or divorced. [widowed circled]
6 (b) Name of husband or wife Dorsey Harman
6 (c) If alive, give age D years
7. Birth date of deceased (mo., day, yr.) Dec. 2. 1878
8. AGE: Years 73 Months 9 Days - If less than one day hr. min.
9. Birthplace Ann Arundel Co Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Caleb Phelps
13. Birthplace "

MOTHER
14. Maiden Name Evelyne Wesley
15. Birthplace "

16 (a) Informant Mrs Mae E Girtel
(b) Address 5513 Magie
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd
18 (a) Funeral director John F Denny Inc, Ho.
(b) Address 795 Light St.
19 (a) Sept 4-47 (Date rec'd by registrar) (b) A. W. Hedrick Registrar
GB

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.9.2 1947 at 915 M
21. I certify that death occurred on the date above stated; that I attended deceased from 8.31 1947, to 9.1 1947 and that I last saw her alive on 9.1. 1947.

Immediate cause of death Acute myocardial Acute myocard failure Pulmonary decompensation

Due to arteriosclerotic

Due to heart disease — Duration 2 yrs

Other Conditions Ulcera cruris

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury H.S. Summers

23. Signature H. S. Summers M. D.
Address 1045 Patapsco Ave Date signed 9.2.47

VS 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emergency Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 07685
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 2 Annapolis
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar HENSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Gabriel Hensen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15 1906

8. AGE: Years	Months	Days	If less than one day
40	7	16	hr. min.

9. Birthplace A. A. Co.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Eliza Hensen
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name Gertrude Cook
15. Birthplace A. A. Co.

16 (a) Informant Mary Hensen
(b) Address A. A. Co.

17 (a) Burial (b) Date thereof Sept 5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Broadneck
Location St. Margretts

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis

19 (a) Sept. 5 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-1947 at 11:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull
Intracranial hemorrhage
Due to
Other Conditions Rupture of left kidney
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-47 at M.
(b) Where did injury occur? Annapolis, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Struck on head with bar

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9/2/47

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Anne Arundel
(a) ~~Baltimore City~~ Maryland
(b) Street address
(c) Hospital or institution: Ft. Meade, Station Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 07686
(a) State Md. (b) County Anne Arundel
(c) City or town Odenton (If outside city or town limits, write RURAL and give Route)
(d) Street No. Cor. Camp Meade & Annapolis (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Halland

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-22-2075

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Henry Holland

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1906

8. AGE: Years 41 | Months 11 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Severn, A.A.Co. Md. (Town, county, and state)

10. Usual Occupation House work

11. Industry or business Own Home

FATHER
12. Name Edward King, Sr.
13. Birthplace Leeland, Prince George, Co.

MOTHER
14. Maiden Name Annie Tucker
15. Birthplace District of Columbia

16 (a) Informant Edward King, Sr. (Father)
(b) Address Odenton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15, 47 (month) (day) (year)
(c) Cemetery or crematory Nichols Memorial
Location Odenton, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Sept 15 47 (Date rec'd by registrar) 9 A.M. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Partial Aut. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intra-cranial Hemorrhage

Due to

Other Conditions
Probably homicide. 10/22/47
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-47 at 11 P.M.
(b) Where did injury occur? Odenton, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Found at bottom of well.

23. Signature: Carl L. Voigt M.D.
Medical Examiner
Date signed 9-12-47

VS 151

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

(B) 076878 Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Herald Harbor, Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 922 G. St. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Wesley B. Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1882.

8. AGE: Years 65 | Months 2 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Sharpsburg Maryland (Town, county, and state)

10. Usual occupation: retired.

11. Industry or business: Wash - Navy Yard.

FATHER — 12. Name: John W. Jackson.

13. Birthplace: Sharpsburg, Md.

MOTHER — 14. Maiden name: Mary V. Hewitt.

15. Birthplace: Sharpsburg, Pa.

16. Informant: Louis E. Goodrich

Address: 1902 Naylor Rd. SE. Wash. DC

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 8 1947 (month) (day) (year)

Cemetery or crematory:

Location: Mt. Rainier, Md.

18. Funeral director: Wm. J. Malley

Address: 3200 - Rhode Island Ave. Mt. Rainier Md

19. Sept. 8 1947 (Date rec'd by registrar) E.T. Joyce Lorie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1947 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination 19.. to Sept. 8, 1947 and that I last saw it alive on Sept. 8, 1947

	DURATION
Immediate cause of death: Coronary occlusion	Sudden
Due to: Coronary Sclerosis	Unknown
Due to: General Arterio - Sclerosis	Unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis, Md. Date signed: 9/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d — 07688 — 20

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Muddy Creek Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Charles Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	widowed

6.(b) Name of husband or wife: Sarah Johnson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1875

8. AGE: Years	Months	Days	If less than one day
72	8	14	..... hrs. ..... min.

9. Birthplace: near Harwood Anne Arundel Co., Maryland
(Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business: general farming
FATHER 12. Name: John Johnson
13. Birthplace: Md
MOTHER 14. Maiden name: unk
15. Birthplace
16. Informant: William H. Brown
Address: Harwood, R. D., Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16 1947 (month) (day) (year)
Cemetery or crematory: Chews
Location: Glenwood
18. Funeral director: J. B. Johnson
Address: Annapolis
19. Sept. 16 1947 (Date rec'd by registrar) J. R. Chew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1947, at 7:30 A.M.
21. I CERTIFY that death occurred on the date above stated, [redacted]
Post mortem Examination
~~and that I last saw him alive on~~ ..... 19.....

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to: Chronic Myocarditis	unknown
Due to: Arterio-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

189

07689

20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cumberstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter W. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ~~Lee Johnson~~

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1947

8. AGE: Years | Months | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberstone, A-A., Maryland
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: Lee Johnson
13. Birthplace: unknown

MOTHER
14. Maiden name: Josephine Dozons
15. Birthplace: Cumberstone A.A.C. Md

16. Informant: Josephine ~~Johnson~~ Dowers
Address: Cumberstone Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13-47 (month) (day) (year)
Cemetery or crematory: Dapel Star
Location: West River Md

18. Funeral director: H. E. Standifer & Son
Address: Galesville Md

19. 9/13 47 (Date rec'd by registrar) 19 ..... Wm. Taylor Registrar
Asst.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12 19 47, at 5 A M

21. I CERTIFY that death occurred on the date above stated: ~~I last attended deceased from~~ ..... to ..... and that I last saw ~~him alive on~~ ..... Post mortem Examination Sept. 12, 1947.

Immediate cause of death	DURATION
Lack of care	
~~Due to~~	
Starvation	
~~Due to~~	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 9/12/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07690

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 10 months, 22 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 years, 10 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1329 Argyle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME

JOHNNIE JONES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:

Years	Months	Days	If less than one day
58	?	?	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Alice Getlet
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-24-47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: William A. Jackson

Address: 916 Penna. Ave.

19. 9/23 19 47 J. W. Tedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18th 19 47 at 6:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27th 19 42, to September 18 19 47 and that I last saw him alive on September 18th 19 47

Immediate cause of death: General Paresis — DURATION: Known to us since 10,27, 1942

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David Marguerite M. D.
M. D. or Other

Address: Crownsville, Maryland Date signed: 9/18/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

RC 97

07691

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 11 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 804 South Howard Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SAMUEL JONES #1

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876 (December 25)

8. AGE: Years: 70 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Samuel Jones
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Julia ?
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/47 (month) (day) (year)
Cemetery or crematory: Western Star
Location: ~~Baltimore~~ Catonsville Md.

18. Funeral director: Chas. L. Cooper
Address: 5122 Annapolis Ave.

19. Sept 30 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27, 1947 at 8:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941, to September 27 1947 and that I last saw h... im... alive on September 27 1947

Immediate cause of death	DURATION
General arteriosclerosis	
Due to	
Due to	
Other conditions: Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 9/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07692

CERTIFICATE OF DEATH

Reg. Diat. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn ~~Baltimore~~ 408 E. Church St.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 719 Portland St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Helen L. Jost

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: John H. Jost

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1869

8. AGE: Years: 78 Months: 1 Days: 17 If less than one day: hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and State)

10. Usual occupation: At Home

11. Industry or business: Ref

FATHER 12. Name: John Thomas Euler

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Atwater

MOTHER 15. Birthplace: Germany

16. Informant: John E. Jost

Address: 408 E. Church St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 1947 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: E. Fork Ave.

18. Funeral director: Wm. Cook Inc.

Address: 1217 St. Paul St.

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 19 47 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/19/46 19 to 9/17/47 19 and that I last saw h... alive on 9/16/47 19

Immediate cause of death: Cerebral hemorrhage, DURATION: few minutes

Due to: Hypertension & Sclerosis, Chronic Interst. Nephritis. Unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John E. Carpenter M. D. or other

Address: Glen Burnie Md. Date signed: 9/18/47

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Severna Park (If outside city or town limits, write RURAL and give nearest town)
Street No.: Sells School (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Kindell
3.(b) Social Security Number

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): December 28th 1929

8. AGE: Years 17 Months 9 Days 2 If less than one day ... hrs. ... min.

9. Birthplace: Long Beach, California (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Nolan M. Kindell
13. Birthplace: Bradford, Ohio

MOTHER
14. Maiden name: Elsie Koehler
15. Birthplace: Manacak, Pennsylvania

16. Informant: Capt. Nolan M. Kindell
Address: Washington, D.C.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct. 4, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Crematory
Location: Prince Geo. County, Md.
18. Funeral director: John M. Taylor + Son
Address: Annapolis, Md.
19. Oct. 3 1947 (Date rec'd by registrar) L. A. Bleit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1947, at Time unknown m.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h... alive on~~ 19

Immediate cause of death: Fracture of skull c̄ Hernia of brain — DURATION
Due to: Amputation of right foot at ankle.
Due to:
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of
Where did injury occur? Severna Park (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) B+A R.R. Tracks
Means of injury: B+A Train (hit by) Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md. Date signed: Oct. 3 1947

VS A15 9-45-15M

07694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: 3611 Patterson St. Chevery Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Edward J. Lockwood, Sr

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Lee Lockwood
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 26, 1886.
8. AGE: Years: 60 58 Months: 8 Days: 11 If less than one day: hrs. min.
9. Birthplace: Brandon, Vermont (Town, county, and state)
10. Usual occupation: Supt of Night Schools & Summer Schools
11. Industry or business: Washington, D.C.

FATHER
12. Name: Fredric Lockwood
13. Birthplace: Tobiting, Vermont.

MOTHER
14. Maiden name: Ford Borah
15. Birthplace: Brandon, Vt.

16. Informant: Edward J. Lockwood Jr
Address: 3611 Patterson St., Chevy Chase, D.C.

17. (Burial, cremation, or removal, Which?) Date thereof: Sept (month) (day) 1947 (year)
Cemetery or crematory: Lincoln Mem.
Location: Md.
18. Funeral director: The S. H. Hipps Co
Address: 2901 - 14th St. N.W.
19. Sept 13 1947 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 - 1947, at 10 45 M

21. I CERTIFY that death occurred on the date above stated: ~~Accordingly~~ Post mortem ~~to~~ Examination 1947 ~~Accordingly~~ 19

Immediate cause of death	DURATION
Due to: Coronary embolism	Sudden
Due to: Coronary sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M.C. or other
Address: Annapolis Md. Date signed: 9/15/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94 a B 07695

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brandonta, Cheshton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Hours
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits write RURAL and give nearest town)
Street No. 1726 - 17th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME Roy Franklin Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Martin.
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Feb. 19 - 1894

8. AGE: Years: 53 Months: 6 Days: 24 If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Dispatcher

11. Industry or business: U.S. International Defense Board

FATHER
12. Name: Henry Martin
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Mrs. Mary M. Martin.
Address: 1726 - 17th St, Washington, DC

17. (Burial, ~~cremation or removal~~? Which?) Date thereof: Sept. 16-47 (month) (day) (year)
Cemetery or crematory: Arlington Nat. Cemetery
Location: Arlington Va

18. Funeral director: The S. H. Hines Co.
Address: 2901-14 st. N.W.

19. Sept 13 1947 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1947, at 9.00 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination, 19..... ~~and that I last saw him alive on~~ 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	sudden
Due to: Coronary sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffey, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07696

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1618 N. Gilmore
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SAMUEL MASON

3.(b) Social Security Number: 213-01-2471

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: Married- Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years: 47 Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER
12. Name: ? John D. Mason
13. Birthplace: Calvert Co Md

MOTHER
14. Maiden name: ? Eliza Jane Hall
15. Birthplace: Calvert Co Md

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1947 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: West port
Funeral director: Va Brooklyn Ringgold
Address: 1463 N. Carey st

19. Oct 2 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30th 1947 at 10:15A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 30th 1947, to September 30 1947
and that I last saw him alive on September 30th 1947

	DURATION
Immediate cause of death: General Paresis	Known to us since 6/30/47
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clark Augustus M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07697

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~29~~ 5 years

Hospital, institution, or street address where death occurred: 29 Eastern Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Eastern Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Meade

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Margaret Meade

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Aug. 5, 1882

8. AGE: Years	Months	Days	If less than one day
~~64~~ 65	1	18	hrs. min.

9. Birthplace: Calvert County, Md. (Town, county, and state)

10. Usual occupation: Deputy Sheriff

11. Industry or business: A.A.-Co.

FATHER — 12. Name: Richard A. Meade

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Annie Hutchinson

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs. Meade

Address: 29 Eastern Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/26/47 (month) (day) (year)

Cemetery or crematory: Glen Haven Cemetery

Location: Glen Burnie, Md.

18. Funeral director: Jos. Wm. Taylor & Son

Address: Annapolis, Md.

19. Sept 25 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23 1947, at 11 20 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ..... 19.. to ..... 19..

and that I last saw h... alive on ..... 19..

Immediate cause of death ..... DURATION

Coronary Occlusion

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. (or other) acting M.E.

Address: Annapolis, Md. Date signed: Sept. 23, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415 9-45-15M

07698

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lindamoor
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ida Sweeting Miller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: Ernest P. Miller
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct 12th 1884

8. AGE: Years 62 | Months 10 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business

FATHER
12. Name: William E. Sweeting
13. Birthplace: Hartford Co. Md.

MOTHER
14. Maiden name: Martha Fouche
15. Birthplace: Unknown

16. Informant: Mrs James L. Purdy
Address: West Annapolis A.A. Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. Sept. 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1947 at 3p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to Sept 8 1947 and that I last saw her alive on Sept 8 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Arteriosclerosis	Unknown
Due to: Diabetes Mellitus	8 years
	8 yrs
Other conditions: Hypertension Myocarditis Chr	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: George C Boone M. D. or other
Address: Annapolis Md. Date signed: 9-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07699

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 4 months, 2 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 3 years, 4 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1710 W. Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: CLARENCE MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1923

8. AGE: Years 24 | Months 2 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Clarence Mitchell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Adelaide Fletcher
15. Birthplace: Maryland

16. Informant: Hospital Records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9. (month) (day) (year)
Cemetery or crematory: Woodlawn Sept 26 47
Location: Balto Md
18. Funeral director: Mrs C B Williams
Address: 3222 N Chrouder St

19. 9/24 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21st 19 47 at 3:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19th 19 44 to September 21 19 47 and that I last saw him alive on September 21st 19 47

Immediate cause of death: Lung-Tuberculosis — Duration: Known to us since 9/17/47

Due to:

Due to:

Other conditions: Epileptic Psychosis — Known to us since 5/19/44

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerchuster M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 9/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Rec'd
9/24/47
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

-8 07700

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Sherwood Forest

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1831 Monroe St NW

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: Harwell Hale Mitchell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married & separated

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16th 1921

8. AGE: Years	Months	Days	If less than one day
26	5	7	hrs. min.

9. Birthplace: Denton, Texas (Town, county, and state)

10. Usual occupation: Jeweler

11. Industry or business:

FATHER — 12. Name: Albert L. Mitchell

FATHER — 13. Birthplace: Texas

MOTHER — 14. Maiden name: Claire A. Pitts

MOTHER — 15. Birthplace: Henrietta, Texas

16. Informant: Mrs. Claire A. Mitchell

Address: 1831 Monroe St. NW Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 26th 1947 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Virginia

18. Funeral director: W. W. Chambers Co.

Address: Washington D. C.

19. Sept. 24, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1947 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19

and ~~that I last saw it~~ alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to: Smoke	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Sept. 24, 1947

Where did injury occur? Sherwood Forest (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Burned in fire Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D. M.D. or other

Address: Annapolis, Md. Date signed: Sept. 24, 1947

Acting M. E.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

36

07701

Reg. Dist. No. 116

1. PLACE OF DEATH:
County Arundel
City or town Sandy Point-Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, Institution, or street address where death occurred:
Ambulance-In route to Baltimore
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Henry St.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3.(a) FULL NAME: Nancy Lee Morgan

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife - - - - - - - - - - - - -

6.(c) If alive, give age - - - years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1943

8. AGE:

Years	Months	Days	If less than one day
3	10	26	....hrs. ....min.

9. Birthplace Seaford, Delaware
(Town, county, and state)

10. Usual occupation - - - -

11. Industry or business - - - -

FATHER
12. Name Martin R. Morgan
13. Birthplace Delaware

MOTHER
14. Maiden name Edith Robinson
15. Birthplace Delaware

16. Informant Mr. Martin R. Morgan
Address Cambridge, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1947 (month) (day) (year)

Cemetery or crematory Blades Cemetery
Location Blades, Delaware

18. Funeral director LeCompte's Funeral Service
Address Cambridge, Maryland.

19. 9-13-1947 (Date rec'd by registrar) John Mace Jr. MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 19 47 at 6:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 19 47 to Sept 12 19 47
and that I last saw her alive on Sept 12, 19 47

Immediate cause of death	DURATION
Respiratory paralysis	6 hrs
Due to Poliomyelitis, acute, ant.	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Lawrence Maryanov M. D. or other
Address 136 Race St., Cambridge Date signed 9/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

07702

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: U. S. Naval Academy (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, Institution, or street address where death occurred: U. S. Naval Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1003 S. Bouldin Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Clark Murphy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: ERNEST MURPHY

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 10 - 22 - 1885

8. AGE: Years	Months	Days	If less than one day
61	11	29	hrs. min.

9. Birthplace: BALTIMORE (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: HOME

FATHER — 12. Name: THOMAS BAYLISS

FATHER — 13. Birthplace: St Louis, ? Mo.

MOTHER — 14. Maiden name: CATHERINE ?

MOTHER — 15. Birthplace: Baltimore ? Md.

16. Informant: ERNEST MURPHY - HUSB.

Address: 1003 S. BOULDIN ST.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9-25-47 (month) (day) (year)

Cemetery or crematory: HOLY REDEEMER

Location: BELAIR RD.

18. Funeral director: LILLY + ZEILER INC.

Address: 403 S. WOLFE ST.

19. 9-23-47 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 19 47, at 2 05 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. Title of other Actg M.E

Address: Annapolis, Md. Date signed: Sept 21, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07703

2000

CERTIFICATE OF DEATH

Reg. Diat. No. 21

Items 12,13,14,15 &16, filmG397 1/24/68 jcp

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

92 Gloucester St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 92 Gloucester St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hannah A. Olivet

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
	W	W

husband or wife: William C. Olivet

6.(c) If alive, give age ..... years

(day, yr.) June 3rd 1846

Years	Months	Days	If less than one day
	3	13	..... hrs. ..... min.

Washington D. C.

(Town, county, and state)

occupation: Home wife

business: Housewife

place: Monongo County, Penna.

name: Catherine Miles

15. Birthplace: Washington, D. C.

16. Informant: Mrs Alvord J. Greenacre

address: 92 Elmwood St Annapolis Md.

17. Burial (cremation, or removal. Which?) Date thereof Sept 19th 1947 (month) (day) (year)

or cremation: Naval Academy

Location: Annapolis Md

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Sept. 17 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 19 47 at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19 ..... to ..... 19 .....

and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
cardiorespiratory failure	
Due to: Shock	
Due to: Heart disease.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Peyton Ritchie M.D. M. D. or other

Address Annapolis, Md. Date signed Sept. 16, 1947

acting M.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

07704

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred: 92 Gloucester St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 92 Gloucester St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Eugene Oliver

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs. Harriet Oliver

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Mar. 18, 1876

8. AGE: Years	Months	Days	If less than one day
71	5	27	..... hrs. ..... min.

9. Birthplace: Geneva Switzerland (Town, county, and state)

10. Usual occupation: Professor, retired

11. Industry or business

FATHER 12. Name: Louis Oliver

13. Birthplace: Switzerland

MOTHER 14. Maiden name: Emma Mussard

15. Birthplace: Switzerland

16. Informant: Mrs. Harriet Oliver

Address: 92 Gloucester St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19th 47 (month) (day) (year)

Cemetery or crematory: Naval Academy

Location: Annapolis Md.

18. Funeral director: John M. Taylor Sons

Address: Annapolis Md.

19. Sept. 17 1947 (Date rec'd by registrar) W. C. Branch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 1947 at 7 00 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

and ~~that I last saw him~~ alive on ..... 19.....

Immediate cause of death	DURATION
Acute dilatation of heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D. Acting M. D. or other

Address: Annapolis, Md. Date signed: Sept. 15, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07705

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Martintown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Martintown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GEORGE WALTER OSBORNE

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife Maria Osborne

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
61			....hrs. ....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name (unknown) Osborne

13. Birthplace Md.

MOTHER 14. Maiden name Fannie Makel

15. Birthplace Md

16. Informant Maria Osborne

Address P. O. Pasadena, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 9-28-47 (month) (day) (year)

Cemetery or crematory Magothy Cem.

Location A. A. Co.

18. Funeral director Jas. E. Hayes

Address

19. 9-25-47 19.... L. A. Bleir Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1947 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended dseceased from June 4 1947 to Sept. 25 1947 and that I last saw h...im alive on Sept. 2 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis (fulminating type)	4 mos
Due to	
Due to	
Other conditions ------	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Bleir M. D.
M. D. of other

Address Pasadena, Md. Date signed 9-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07706

Reg. Dist. No. 28

1. PLACE OF DEATH
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 17 days
Hospital, institution or street address where death occurred: Crownsville State Hospital, Maryland
How long in hospital or institution? 2 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1513 Laurens Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES PERRY

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife: Unknown to us

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: 46 Years | Months: ? | Days: ? | If less than one day: hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 9/23-47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Butler Hospital
Address: Crownsville Md Local

19. 9/23-47 19 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11th 1947 at 10:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25th 1947 to September 11 1947
and that I last saw him alive on September 11th 1947

Immediate cause of death: General Paresis — DURATION: Known to us since June 25, 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Mayerndon M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 9/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

07707

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 11 months, 12 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland

How long in hospital or institution? 3 years, 11 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 552 W. Preston St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPHINE PRICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us 1871

8. AGE:

Years	Months	Days	If less than one day
76	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Charles Price
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Crane
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22-47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Dept Hospitals
Address: Crownsville Md

19. 9/22 1947 E J Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16th 1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from October 4th 1943, to September 16 1947 and that I last saw h er alive on September 16th 1947.

Immediate cause of death	DURATION
Fracture of the neck, fracture of left Tibia and Fibula	
Due to: Contusions and small Lacerations	
Due to: On bedback	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 9-16-47
Where did injury occur? Crownsville (City or town) A.A., (County) Maryland (State)
Injured at home, farm, industry, public place (where?): State Hospital
Means of injury: fell or walked out window Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy Chief Examiner
M. D. or other
Address: Annapolis, Maryland Date signed 9-16-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

726 07708

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 63 Washington Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 63 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Louis Price

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Gertrude Price
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 12, 1899

8. AGE: Years	Months	Days	If less than one day
~~47~~ 46	10	1	..... hrs. ..... min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: General Utility
11. Industry or business: None

FATHER
12. Name: William Price
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Lola Henson
15. Birthplace: Atlantic City N.J.

16. Informant: Gertrude Price
Address: 63 Washington Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-17-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West St Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Sept. 16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13, 1947, at 6.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8, 1947, to Sept 13, 1947 and that I last saw h[illegible] alive on Sept 13, 1947

Immediate cause of death	DURATION
Cardiac Failure	5 days
Due to: Mitral Insufficiency	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Theodore R. Johnson M. D. or other
Address: 40 Hillsdale Ave. Date signed 9/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07709

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 9 months, 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Maryland
How long in hospital or institution? 1 year, 9 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 505 Pennsylvania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: HORACE RAWLINGSON (ROLLINSON)

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Unknown to us
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1910

8. AGE: 37 Years | Months ? | Days ? | If less than one day: hrs. min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Shoe Maker

11. Industry or business:

FATHER
12. Name: Joe Rollinson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Mamie?
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville State Hospital, Maryland

17. Burial, cremation, or removal. Which?: burial
Date thereof: 9/22/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

16. Funeral director: Supt Hospital
Address: Crownsville Md

19. 9/22/47 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7th 1947 at 8:45A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2nd 1935 to September 7th 1947 and that I last saw him alive on September 7th 1947

	DURATION
Immediate cause of death: Lung Tuberculosis Known to us	since 9/3/47
Due to:	
Due to:	
Other conditions: Psychosis With Other Somatic Disease - Lues (Include pregnancy within 3 months of death)	Known to us since 12/2/1935

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph Morgenstern M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 9/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

07710

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State: Maryland County: Prince George
City or town: near Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Vincent Ring

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 25, 1942.

8. AGE:

Years	Months	Days	If less than one day
4	9	11	hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Joseph A. Ring
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Mary Willis
15. Birthplace: Boston, Massachusetts

16. Informant: Joseph A. Ring
Address: Annapolis, P.O. Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 5 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Bowie Church
Location: Bowie Md
18. Funeral director: M. J. Leading Son
Address: Bowie Md

19. Sept 5 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1947 at 4.00 p M

21. I CERTIFY, that death occurred on the date above stated, that I attended deceased from
Post mortem Examination
Sept. 5 1947
and that I last saw h alive on
Immediate cause of death: Fracture of Skull — DURATION
Due to: Fracture of neck
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of injury: 9/5/47
Where did injury occur? near Whitemarsh P.G. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Crain Highway
Means of injury: automobile Injured at work? no

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 07713

Reg. Diet. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ANNE ARUNDEL Co.

City or town LAKE SHORE PASADENA MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County ANNE ARUNDEL

City or town LAKE SHORE

(If outside city or town limits, write RURAL and give nearest town)

Street No. PASADENA, MD.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME THOMAS JAMES RYAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife MARY H. RYAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 12, 1893

8. AGE: Years	Months	Days	If less than one day
54			..... hrs. ..... min.

9. Birthplace BALTO (Town, county, and state)

10. Usual occupation MOTORMAN

11. Industry or business .....

FATHER 12. Name JOHN RYAN

13. Birthplace IRELAND

MOTHER 14. Maiden name UNKNOWN

15. Birthplace GERMANY

16. Informant MRS MARY RYAN

Address LAKE SHORE, PASADENA MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9 25 47 (month) (day) (year)

Cemetery or crematory HOLY CROSS

Location RITCHIE HIGHWAY

18. Funeral director JOHN F. DENNY, INC

Address 715 LIGHT ST. -30

19. Sept 25 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 23, 19 47, at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 19 47 to Sept 23 19 47 and that I last saw h.. alive on Sept 17 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	Sudden
Due to Hypertension	Long duration
Due to Myocardial Insufficiency	Due to
Other conditions	Month

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Leon S. Horka M. D. or other

Address 4200 Pennington Ave. Date signed Sept 25 47

Dr. Korka
4700 Pennsylvania Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

07712

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft George G Meade
(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 62/365

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 2 Hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 East Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war: - -

3. (a) FULL NAME: Aliese Keene Schwoyer

3. (b) Social Security Number: - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 26 July, 1947

8. AGE: Years	Months	Days	If less than one day
None	2	2	- hrs. - min.

9. Birthplace: Ft George G Meade, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: - -

FATHER
12. Name: Anthony E Schwoyer
13. Birthplace: Allentown, Pa.

MOTHER
14. Maiden name: Helen Frances Keene
15. Birthplace: Baltimore, Md.

16. Informant: Medical Records
Address: Station Hosp., Ft Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sep 29 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Anne Arundel County, Md.

18. Funeral director: Charles P. Towell

Address: 2427 Edmonson Ave., Balto., Md.

19. 28 Sep 1947 (Date rec'd by registrar) James N Goerger, Capt. MAC (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1947 at 1325 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1947, to 28 Sept 1947 and that I last saw h... alive on Sept 28 1947

Immediate cause of death	DURATION
Heart failure, acute	
Due to Congenital malformation	
Due to Unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lowell F. Peterson, Capt. MC (M.D. or other)
LOWELL F. PETERSON, CAPT. MC
Address: Sta. Hosp. Ft. Meade Date signed: 29 Sept 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

183

07713

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Beechwood Park Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Magotty River.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 788 West Mulberry
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Wardell Ray Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 2, 1947 1920

8. AGE:

Years	Months	Days	If less than one day
27	2	11	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Stevedore
11. Industry or business
FATHER 12. Name: John William Scott
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Agnes A. Frost
15. Birthplace: Baltimore, Maryland
16. Informant: Agnes Scott (wife)
Address: 788 W. Mulberry St
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/47 (month) (day) (year)
Cemetery or crematory: Balto. Md.
Location: Balto. Md.
18. Funeral director: Chas. H. Corbin
Address: 512 N. Carrollton Ave.
19. Sept 17 1947 (Date rec'd by registrar) A. D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1947 at 5:05 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~and that I last saw her alive on~~ Post mortem Examination Sept. 13, 1947

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9/13/47
Where did injury occur? Pasadena (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Magotty River
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 C

07714

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a. a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 166 west St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Stromeyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Frank Stromeyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1 — 1873

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis md (town, county, and state)

10. Usual occupation Home work

11. Industry or business

FATHER 12. Name Geo Clark

13. Birthplace Maryland

MOTHER 14. Maiden name Margaret Rydings

15. Birthplace Maryland

16. Informant William F Stromeyer

Address 166 west St Annapolis md

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 12/47 (month) (day) (year)

Cemetery or crematory St annes

Location annapolis md

18. Funeral director B E Hopkins & Son

Address annapolis md

19. Sept 12 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 47, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 47 to Sept 9 19 47 and that I last saw h alive on Sept 9 19 47

Immediate cause of death Carcinomas Stomach — DURATION: uncertain

Due to

Due to

Other conditions Acute Edema — DURATION: uncertain

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boarman M. D. or other

Address Annapolis Md Date signed 9-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

07715

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 West Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Nelson Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Flora M. Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 18th 1881

8. AGE: Years	Months	Days	If less than one day
65	9	17	hrs. min.

9. Birthplace: Annapolis - A.A.Co. - Md.
(Town, county, and state)

10. Usual occupation: Veterinarian

11. Industry or business

FATHER
12. Name: Samuel K. Taylor
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Mary E. Redmond
15. Birthplace: Annapolis, Md.

16. Informant: Mrs. Flora M. Taylor
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7th 1947 (month) (day) (year)

Cemetery or crematory: St. Annes Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis, Maryland

19. Sept. 7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1947, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1938, to Sept 5 1947

and that I last saw h[illegible] alive on Sept 5 1947

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to: Arteriosclerosis — 9 yrs

Due to:

Other conditions: Hypertension — 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Boarman M. D. or other

Address: Annapolis Md. Date signed 9-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

74a

07716

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
8 Elm Street, Homoja Vlg. Annapolis Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Elm St., Homoja Vlg.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROBERT VERNON TEIG

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 3, 1945

8. AGE: Years: 2 | Months: 0 | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pensacola, Florida
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Vernon Teig
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Lillian Johnson
15. Birthplace: Minnesota

16. Informant: Mrs. Vernon E. Teig
Address: 8 Elm St, Homoja Vlg. Annapolis.

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: Sept 4, 1947
(month) (day) (year)

Cemetery or crematory: Lakefield, Minnesota
Location

18. Funeral director: B. L. Hopping & Son.
Address: 170-172. West St. Annapolis, Md.

19. Sept. 4, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3, 1947, at 4:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May, 1946 to Sept. 1947 and that I last saw h... 1m alive on Sept. 3, 1947

Immediate cause of death	DURATION
Gastro-intestinal hemorrhage	24 hrs.
Due to: leukemia, Acute Lymphatic	6 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thomas W. Green
Lt jg (MC) USNR
M. D. or other
Address: US Naval Hospital
Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

182

07717

Reg. Diet. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 week
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Fairfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3318 - Tate
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Larry George Vaughn.

3.(b) Social Security Number:

4. Sex: M.
5. Color or race: Black
6.(a) Single, married, widowed, or divorced: Single.
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug. 5th - 1947
8. AGE: Years | Months: 1 | Days: 25 | If less than one day: hrs. min.
9. Birthplace: City Hospital, Baltimore, Md. (Town, county, and state)
10. Usual occupation: None.
11. Industry or business:
FATHER 12. Name: Robert Walston
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Thelmenia Vaught
15. Birthplace: Baltimore, Md.
16. Informant: Thelmenia Vaught (mother)
Address: 3318 - Tate St. - Fairfield, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof October 3 1947 (month) (day) (year)
Cemetery or crematory: Mount Auburn Cemetery
Location: Baltimore City
18. Funeral director: Joseph Arthur Lucky
Address: 6 61 West Lane St. Baltimore Maryland
19. 10/1 1947 (Date rec'd by registrar) L. P. DeAlba ACTING Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 1947, at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Asphyxia -	Sudden
Due to: (Baby slept with mother in bed.)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9/30/47
Where did injury occur? Hanover A. C. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home.
Means of injury: Slept in mother. injured at work? No

23. SIGNATURE: Gustave D. Pember M.D.
Address: Glen Burnie Md. Date signed: 9/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

07718

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Parole

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred: Shady Oaks Inn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Parole

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural nr. Annapolis, Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CLEMENS HERMAN WAGNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna M. Wagner

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 12, 1867

8. AGE: Years	Months	Days	If less than one day
80	5	17	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Owner

11. Industry or business: Shady Oaks Inn

FATHER — 12. Name: John Herman Wagner

13. Birthplace: Germany

MOTHER — 14. Maiden name: Clara Pauline Timmeller

15. Birthplace: Cederay, Saxoney, Germany

16. Informant: Mrs. Anna M. Wagner

Address: Shady Oaks Inn Parole, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-2-47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Oct. 1, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 1947, at 2.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Sept 29 1947 and that I last saw h... alive on Sept 29 1947

	DURATION
Immediate cause of death: Cardio Vascular Failure	about 1 week
Due to: Dehydration + Plow Elevation	about 2 mos
Due to: Gastrectomy Dem Feb 11/47	
Other conditions: Cancer of Stomach (Include pregnancy within 3 months of death)	about 1 yr

Major findings of operations: Stomach Cancer

Date of op. Feb 11/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Owen Purvis M. D. or other

Address: Annapolis Md Date signed: 10/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07719

Reg. Diat. No. 2c

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 17 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crimsville, Md.

How long in hospital or institution? 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 628 W. Lanvale Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WARD - BENJAMIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Margaret Murray Ward

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 47 | Months: ? | Days: ? | If less than one day: hrs. min.

9. Birthplace: District of Columbia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Nathan Ward
13. Birthplace: District of Columbia

MOTHER
14. Maiden name: Martha
15. Birthplace: District of Columbia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 47 (month) (day) (year)

Cemetery or crematory: St. Peters.

Location: Baltimore City

18. Funeral director: Geo. G. Kelson

Address: 1303 Presstman St.

19. Sept 25, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23rd, 1947, at 4:45P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6th, 1946, to September 23, 1947, and that I last saw him alive on September 23rd, 1947

	DURATION
Immediate cause of death: General Paresis	Known to us since December 6, 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or Other

Address: Crownsville, Maryland Date signed: 9/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07720

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Round Bay
City or town anne arundel Co
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel Co
City or town Round Bay (Severn R. Rd)
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war no —

3. (a) FULL NAME Turner Barrie Waters

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Della Barrington Black
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 28 1870

8. AGE: Years	Months	Days	If less than one day
76	9	11	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Post master
11. Industry or business

FATHER
12. Name James Brown Waters
13. Birthplace Balto city

MOTHER
14. Maiden name Theodocia Thomas
15. Birthplace Balto City

16. Informant Zelia Waters
Address Round Bay Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Sept 13 47 (month) (day) (year)
Cemetery or crematory Greenmount
Location Balto city

18. Funeral director Wm cook Inc
Address 1217 St Paul St

19. 9/11 19 47 H.W. Hedrick Dr Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 47, at 7 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 40, to Sept 10 19 47
and that I last saw him alive on Sept 8 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Chron. Interstitial Nephritis & Hypertension	5 years
Due to Diabetes	10 years
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James S. Bellinger M.D
M. D. or other
Address Glen Burnie Md Date signed Sept 11, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

07721

Reg. Diat. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years.

Hospital, institution, or street address where death occurred:

Waterbury Md-

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne-Arundel

City or town: Rural Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Elias Wilson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Liza Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE:	Years	Months	Days	If less than one day
	73			..... hrs. ..... min.

9. Birthplace: Mt Tabor Anne Arundel Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: None

FATHER

12. Name: Elias Wilson Sr.

13. Birthplace: Mt Tabor

MOTHER

14. Maiden name: Unknown

15. Birthplace: Mt Tabor

16. Informant: John T Wilson

Address: 22 NW Street Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 19-47 (month) (day) (year)

Cemetery or crematory: John wesley Cemetery

Location: Waterbury A. A. Co. Md.

18. Funeral director: Mrs Charles G. Hicks.

Address: 45 Northwest St Annapolis Md.

19. Sept. 19 19 47 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 19 47 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 13 19 47 to September 16 19 47 and that I last saw h.i.m. alive on September 15 19 47

	DURATION
Immediate cause of death: Cerebral Thrombosis	4 Days
Due to: Hypertensive Cardio-Vascular Disease	1 Year
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward J Thornett M.D. M. D. or other

Address: Gambrills Md Date signed 9-16-47

07723

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Severna Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: none Balto.

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1900 Oak Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME (John Otis Worden) John Otis Worden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 8. 1872

8. AGE: Years 76 | Months 7 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Vermont (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER — 12. Name: Edwin E. Warden
13. Birthplace: Vermont

MOTHER — 14. Maiden name: Catherine Laffe
15. Birthplace: Vermont

16. Informant: Mary E. Warden
Address: 1900 Oak Drive Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23 19 47 (month) (day) (year)

Cemetery or crematory: Newton Cemy.

Location: Newton Mass.

18. Funeral director: John O. Mitchell Sons

Address: 1900 Eutaw Place

19. 9-22 19 47 (Date received by registrar) J-W. Medical Dir. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 19 47, at 11 45 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 to 19 ~~and that I last saw h alive on~~ 19

Immediate cause of death	DURATION
coronary occlusion	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Rt. Hemiplegia (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Rittenhouse M.D.
M.D. or other

Address: Annapolis, Md. Date signed: Sept 20, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M